

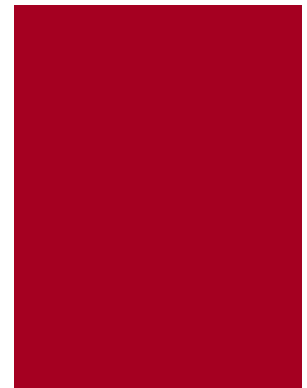


Canadian Interprofessional Health Collaborative
Consortium pancanadien pour l'interprofessionnalisme en santé

*learning to work together, working to learn together
apprendre à collaborer, collaborer pour apprendre*

Focus Group Report

on
Knowledge Transfer & Exchange in Interprofessional
Education: Synthesizing the Evidence to Foster Evidence-based
Decision-making



The Canadian Interprofessional Health Collaborative (CIHC) promotes collaboration in health and education. We are a group of educators, policymakers, researchers, health providers, students and citizens from across Canada who believe interprofessional education and collaborative patient-centred practice are key to building effective health care teams and improving the experience and outcomes of patients. The CIHC identifies and shares leading practices and its extensive and growing knowledge in interprofessional education and collaborative practice.

The Canadian Interprofessional Health Collaborative would like to acknowledge funding support from Health Canada.

The views expressed here do not necessarily represent the views of Health Canada.

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CIP data will be made available

ISBN tk

Acknowledgements

The CIHC would like to thank all of the individuals who graciously donated several hours of their time to participate in these focus groups. Your advice, knowledge and recommendations have been invaluable in improving the *Evidence on Interprofessional Education* document and helping CIHC set its strategic workplan for the next few years.

Thank you for your insight and support. It was a pleasure!

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SOURCE DOCUMENT

Canadian Interprofessional Health Collaborative. (2009). *Knowledge Transfer & Exchange in Interprofessional Education: Synthesizing the Evidence to Foster Evidence-based Decision-making*. Vancouver, BC.

http://www.cihc.ca/resources-files/CIHC_EvidenceForIPE_revMay2009.pdf

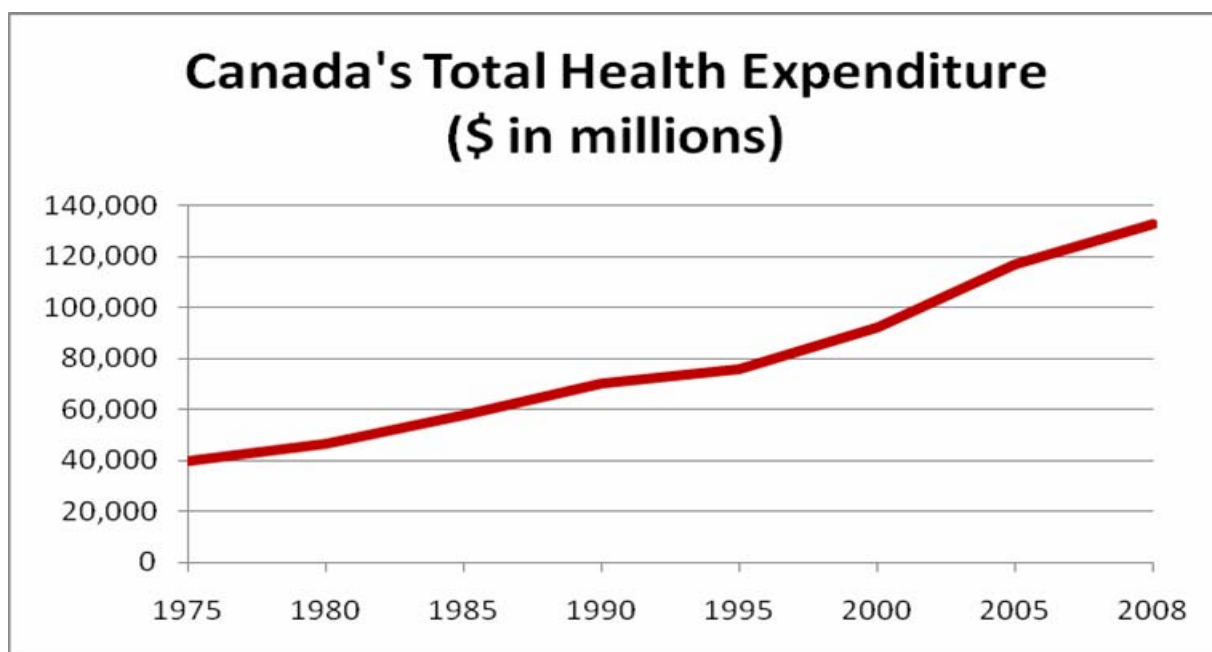
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Part One: Introduction

The Canadian International Health Collaborative was founded in 2006 when Dr. John Gilbert identified a need to link Health Canada's 20 Interprofessional Education for Collaborative Patient-Centred Practice (IECPCP) projects to one another in order to share promising practices and help advance interprofessional collaboration across the healthcare system. Since its inception, CIHC has become the hub for interprofessional education and collaborative practice in Canada and has made enormous inroads into broadening the uptake of these important strategies as a true and lasting means of making significant health system change.

While interprofessional education and collaborative practice are not the panacea to all of the challenges facing Canada's healthcare system, the benefits of improved teamwork, greater efficiencies, less duplication and better decision-making, cannot be ignored. Interprofessional collaboration has been shown to boost the job satisfaction of healthcare providers (which reduces the attrition rate), and improve the efficiency of a patient-centred healthcare team. At a time when the cost of healthcare is rising dramatically year over year, this is one of the areas where policymakers see potential for lasting, sustainable change.



Canadian Institute for Health Information, 2008.

If policymakers are going to make long-term investments in interprofessional education and collaborative practice, they must first have access to evidence-based research that demonstrates the benefits of this type of practice. Policymakers and academics have spent considerable time and effort working to understand what the system needs to move toward improved collaboration within the healthcare system. At the same time, policymakers have asked CIHC to provide them with succinct, evidence-based information they can use to educate, advocate and

promote interprofessional education and collaborative practice as a necessary requirements for health system reform.

The challenge for the CIHC has been in responding to the inquiries of policymakers with strong, compelling evidence for why they should consider interprofessional education and collaborative practice as key tools for health system planning. Researchers and experts in interprofessional education and collaborative practice acknowledge that there is limited evidence to prove these methods make a difference in patient and health system outcomes. To many health providers and administrators, it seems intuitive. How could improved teamwork, better communication, increased respect for colleagues and shared decision-making not be beneficial to the health system? Yet the evidence that supports this thinking is inconsistent and not always applicable to the needs of policymakers. In addition to the lack of solid evidence, the evidence that does exist is primarily written by and for an academic audience, and is not easily understood outside of the existing core group of advocates.

In March 2008, the CIHC Secretariat, under the leadership of Evaluation Director, Dr. Scott Reeves, conducted a synthesis of existing evidence reviews on interprofessional education. In this synthesis, Dr. Reeves evaluated six systematic reviews reporting on the effects of 181 interprofessional studies which occurred between 1974 and 2005. Dr. Reeves findings make up the Technical Report, while the accompanying 1-page Evidence Review and 2-page Frequently Asked Questions, drew upon the findings of the Technical Report and were targeted to policymakers. The intention of these short, concise, evidence-based documents (posted on the CIHC website in July 2008) was to support the need for interprofessional education. For the purposes of this study, Collaborative Practice was not included in the Synthesis, although there is a commonly accepted belief that interprofessional education is necessary in order to achieve collaborative practice

Upon the completion of the documents, the CIHC Secretariat made the decision to seek policymaker opinion on the usefulness of the pieces that had been “translated” – specifically the Evidence Review and Frequently Asked Questions. Subsequently, from October to December 2008, the CIHC hosted a series of focus groups to discuss the practicality and usefulness of the documents. Focus groups were held in Toronto, Ontario; Saskatoon, Saskatchewan; St. John’s, Newfoundland; Winnipeg, Manitoba and Vancouver, British Columbia. Each session engaged approximately 10 individuals, the majority of whom were in senior leadership roles within government, health authority, regulatory, university or clinical settings.

In May 2009, CIHC reposted updated versions of the Evidence Review and Frequently Asked Questions, incorporating many of the suggestions and recommendations that were made during the focus groups. These documents can be found at http://www.cihc.ca/resources-files/CIHC_EvidenceForIPE_revMay2009.pdf . This document describes the outcomes of the focus groups, the changes that were recommended and later incorporated, and some general observations about the evidence needed and wanted by policymakers.

Although the focus groups were targeted at updating and analyzing specific documents, much of the discussion that occurred took on much broader challenges, issues and recommendations for interprofessional education and collaborative practice. The overarching themes of these conversations can be found in Part Two of this document, or by reviewing Appendix C: Transcripts of the Focus Groups.

FOCUS GROUPS

To our knowledge, this series of national focus groups was the first of its kind focusing on interprofessional education and collaborative practice in Canada. For the first time, policymakers (both supporters of interprofessional education and collaborative practice and those without background or interest) sat down in a room to discuss what types of information and evidence they would need in order to promote, recommend or support enhancing or expanding their jurisdiction's focus on interprofessional education.

In order to ensure some comparability between focus groups, the same set of questions were asked at each meeting. Throughout the discussion, the 'scribe' noted key changes and themes on a white board and towards the end of the session, participants were provided with paper and asked to rank the changes and themes from most important to least. These themes have been compiled and compared. For a collated list of simple changes to the document (language, grammar, editing, look) please see Appendix A. The larger, overarching themes which were common throughout each of the five focus groups are discussed in more detail in Part Two.

POLICYMAKER QUESTIONS

The following schedule was used for each of the focus groups and anticipated a focused nominal group meeting of approximately 60 – 90 minutes.

'The Document' refers to the Evidence Review and Frequently Asked Questions, which participants were provided with prior to and during the meeting. In some focus groups, discussion also touched on the Technical Report, however, this was not the focus or primary subject of the facilitated sessions.

1. Introductions – Names, roles, interest/connection to interprofessional education
2. Clarity of Materials – Are the documents clear and concise? Do they have the correct tone?
3. Usefulness of Materials – As a decision-maker, how useful are these documents?
4. Using the Materials – As a decision-maker, how and when would you use these documents?
5. Improvements - How might the quality of these documents be improved?
6. Direction – What types of documents or information could CIHC provide or develop that would be the most use for you.
7. Final Thoughts and Comments

Part Two: Common Themes Arising From the Focus Groups

Because the discussion followed the same format throughout each focus group, many of the groups noted similar themes and changes they would like to see occur with the document or in the direction CIHC could next take to better promote interprofessional education and collaborative practice. These changes were noted and some have been incorporated into the 1-page Evidence Review.

However, some of the overarching themes went far beyond minor changes and discussed in much more detail the importance of evidence to policymakers, the types of information that might be more beneficial, and generally how the document (and inadvertently all documents and dissemination of CIHC) could be improved. In particular, five themes were recurrent in all five focus groups.

THEME 1: SHIFT FOCUS TO COLLABORATIVE PRACTICE

Although most policymakers agree that interprofessional education is an important building block for collaborative practice, by far the number one issue identified by each focus group was the need for CIHC to move the focus from academia to the practice setting. There is a strong feeling among policymakers that the education piece is already well underway in most universities and college within Canada. While most would readily admit that there remains work to be done to ensure all health science and social service students receive at least one interprofessional course during their education, the general consensus is that many education institutions are now moving in this direction. However, this same sort of interest and uptake is not being reflected on the practice side at this time. This is a challenge for two primary reasons. It is not beneficial to provide students with interprofessional education if they are unable to find positions upon graduation that allow them to practice in a collaborative practice setting. At the same time, if practicing health providers are not exposed to interprofessional education (through continuing education or other types of programs), they may not have the infrastructure, supports or knowledge to embrace graduating interprofessional students. Regardless of their approach, there was fairly universal agreement among participants that the 'meat' of this strategy is collaborative practice, and without turning our attention to the practice side, we will not have success.

In terms of the *Knowledge Transfer & Exchange in Interprofessional Education: Synthesizing the Evidence to Foster Evidence-based Decision-making*, discussion would have stalled if we had limited the conversation to interprofessional education only. This presented something of a challenge as this particular evidence review focused solely on evidence reviews about interprofessional education. Most of the focus groups attendees, including those from the education sector, recognized that a document focusing solely on interprofessional education, that didn't make the linkages to collaborative practice and ultimately better patient outcomes, would be irrelevant to their work. Some individuals, particularly from regulatory bodies, government and health authorities, were quite frank in stating that unless the document and evidence gathered contained information on the impact and effectiveness of collaborative practice, they would have no opportunity to use it to further inform their decision-making processes or that of their organization.

Clearly, the current thinking from policymakers is that interprofessional education is part of collaborative practice, but the important change that needs to take place is in the practice environment. The focus (whether research, dissemination, partnerships, activities, etc.) needs to be first on collaborative practice, because that is where changes can be measured, monitored and used to promote system change. This information, while not unexpected, was a strong indicator to CIHC of the direction the organization should take in the next few years, and as such, these conversations were invaluable to the organization.

THEME 2: DUDE, WHERE'S MY PATIENT?

One of the challenges facing the community of individuals involved in interprofessional education and collaborative practice, most of whom are currently from an academic background, is the tendency to lose sight of the patient (or client/family/community) in our discussion and evaluation. Many of the individuals who are working so diligently to move interprofessional collaboration forward simply do not work in the practice environment and have no interaction with patients. For many of the focus group attendees, particularly those from the practice environment, this is one of the most significant challenges to moving interprofessional education and collaborative practice forward in the practice setting.

The focus group in Newfoundland in particular, noted that under Primary Health Care funding, quite a bit of work was done on interprofessional collaboration, but that work focused on patient and community outcomes. Regulators in Vancouver felt that unless patient safety, the very heart of their work, was somehow incorporated into the work of the CIHC and this document in particular, it would be hard for them to invest much time and attention in moving the document forward. Policymakers in the Winnipeg focus group questioned whether the local Health Canada funded IECPCP (Interprofessional Education for Collaborative Patient-Centred Practice) projects included patient outcomes or patient satisfaction surveys. Unfortunately, as noted by one of the IECPCP project leads in attendance, the 20 projects were based in education institutions and focused on education programs. As a result, most of the projects had minimal direct patient interaction and measured primarily educational components. For policymakers who attended the focus groups, this lack of patient inclusion and outcomes was one of the biggest oversights of both the evidence presented in this 1-page Evidence Review, and the current direction of those working to advance interprofessional education and collaborative practice in Canada. Without being able to identify how this work will impact an individual or community in Iqaluit or Montreal or Red Deer, policymakers will have a difficult time convincing others to support this work.

Many focus group attendees identified the 1-page Evidence Review as seeming cold and impersonal. While the language and readability were generally applauded, the lack of personality – case studies, quotes or experiential accounts – was frequently cited as a turnoff for participants. Many felt that the voice of real people – patients or health providers – would have been much more compelling and made interprofessional education much more accessible and human and demonstrated how it links to collaborative practice.

THEME 3: BUILD A RESEARCH AGENDA TO MATCH POLICYMAKER NEEDS

Following on the heels of the confusion over why and how the interprofessional education and collaborative practice movement may have lost the patient, was the general agreement that the type of evidence that would help policymakers make a case for increased interprofessional collaboration, is not currently being collected

The Winnipeg focus group in particular identified a number of key areas of research that they, as policymakers, would like to see undertaken. For example, could a study be designed to determine whether interprofessional teams of health providers have a better understanding of who they should be consulting with and whether they are consulting with (and referring to) the appropriate team member. Or could researchers develop a way to measure if a patient's length of stay in hospital is reduced when an interprofessional team is managing their care (for example, could it be assumed that by having the appropriate team gathered from the outset of treatment, referral times may be reduced.)

It was evident during the focus groups that connections between policymakers and those who are doing research in interprofessional education and collaborative practice, have not been made with any sort of regularity. Both sides would benefit from more frequent conversation and discussion about designing a research agenda that engages the researchers, meets the needs of the policymakers; and has potential for a positive outcome on patients. The focus groups were not designed to delve deeply into this topic, yet the policymakers had very definite opinions about the types of information and evidence they need to really promote interprofessional education and collaborative practice. Meanwhile researchers were often surprised with how easily some of these research programs could be designed and implemented – they just hadn't been aware of some of the particular needs.

For CIHC, there is a clear indication from the focus groups that researchers and policymakers need to connect more regularly to share work that is going on and discuss what work would be most beneficial. This is something CIHC can facilitate and further meetings and discussions will be organized in keeping with the 2009-2011 workplan.

THEME 4: DON'T BE AFRAID OF THE DATA

One of the more common complaints was that the language in the 1-page Evidence Review was 'wishy washy' or on the opposite end of the scale 'contained too much spin'. This is an interesting observation, and one that was also noted within the authorship group. Policymakers were looking for definite statements "IPE is" and "IPE can" etc. Researchers felt that the document should be blunt about the "elephants in the room". As noted in theme two, more discussion between researchers and policymakers will likely help to bridge some of the gap that exists between the two groups to come to a consensus on what language is most appropriate.

Each of the focus groups reacted very strongly to the way qualitative and quantitative data were incorporated in the evidence reviews and the summary of the evidence reviews. Many noted that while there is often a push for quantitative data around projects such as interprofessional education and collaborative practice, there is a lot of validity in qualitative data as well. If 25

students think an interprofessional program has changed their life and the way they will practice, that is useful information for policymakers, even if the information is anecdotal.

In general, people felt that a mix of qualitative and quantitative data would be helpful to policymakers, practitioners and students and that both have legitimacy in proving the case for interprofessional education and collaborative practice.

THEME 5: BUILD ON KEY HEALTH SYSTEM PRIORITIES

Many participants in the focus groups recognized that there is a need to tie interprofessional education and collaborative practice into current health system challenges and priorities, in order to ensure they are recognized as a necessary change in the healthcare system. There were a variety of concerns about whether or not interprofessional education and collaborative practice can positively impact the health human resource shortage, which the original 1-page Evidence Review cited as one of the benefits of interprofessional education. Others felt that interprofessional education does not, in fact, impact any health system priorities, but rather that the *product* of interprofessional education – collaborative practice – is what will impact on health system priorities.

Most felt strongly that collaborative practice would most likely strengthen issues around patient safety, community health and primary health care. Proving that interprofessional collaboration can actually benefit these key health system issues is an important way to ensure policymakers can make a case for supporting interprofessional education and collaborative practice.

Ultimately, several participants noted that what is needed is evidence that states the benefit of interprofessional collaboration on patients. Secondary to that are questions about the cost (or reduced cost) to the system, the impact collaborative practice has on health providers working in a collaborative setting, and whether health science and human service students who have taken part in interprofessional education, carry the learned attitudes and knowledge with them into the practice setting, and base their practice on those principles for years to come.

Conclusion

The focus groups that were held across Canada provided CIHC with a wealth of information, not only on the documents under discussion, but on the current thinking and activity around interprofessional education and collaborative practice amongst decision-makers and policymakers from coast to coast. Although there was much appreciation expressed for CIHC in developing documents such as the 1-page Evidence Review, FAQs and Technical Report, as well as general support for the work that CIHC is doing, a number of clear messages were put forward that will inform the future direction of the organization.

The strongest message, by far, to come out of this exercise, is that the focus of the CIHC must shift from academia to the practice environment. Whether individuals hailed from regulatory colleges, government, health authority, professional association, university administration or practice, CIHC was given very clear notice that collaborative practice is the goal, while interprofessional education is a lever to reaching that goal.

The original 1-page Evidence Review critiqued by the focus groups contained the sub-heading “Now is the time to get involved”, which many felt was confusing – particularly since there was no clear indication of who should get involved and what they should get involved in. Perhaps one of the lessons we have learned is that “now is the time for the IECPCP (Interprofessional Education for Collaborative Patient-Centred Practice) projects, supporters, champions and partners to get involved”. We have done a lot of work on interprofessional education, but as one participant said “if this sheet crossed my desk, I wouldn’t look at it, unless you took away the “E”, because at the end of the day, the “E” is not my business”.

There’s no question that interprofessional education plays an important role in developing the knowledge, skills and attitudes needed for health providers to practice in collaborative settings. It is encouraging that the education sector has made such strong inroads into ensuring that interprofessional education is embedded in health provider education. The expectation across the country is that this level of interest and commitment will continue and become even more prevalent. With the education sector in hand, policymakers, decision-makers, regulators, accreditors and others are sending a clear message that it is time to shift focus to collaborative practice. These focus groups reiterated that very clearly, and the opinions and recommendations expressed by attendees were invaluable to setting the direction of CIHC for the future.

Appendix A – Short Summary of Document Changes

EVIDENCE REPORT

- “Now is the Time to Get Involved” – this was a theme that came up a number of times with various groups. Most agreed that the statement doesn’t fit the rest of the document and should be taken off. One suggestion in Vancouver was to call it the second part “Now is the Time...” and strengthen the rest of the piece to make it fit.
- “While the quality of evidence is improving...” - this is a self-defeating statement, turn it into a positive
- Delete definitions & definitions box
- The end needs to be strengthened to bring in CP if we want this to be a tool that funders and decision-makers can use
- CQI or TQM – lots of strong reaction to this – most felt it needed to come off, was out-of-date, is no longer part of the lingo, does not add value, etc.
- Bullets should be re-ordered “IPE has the potential to enhance...” should be first. Focus on collaboration first, IPE second
- Need to put a date on this
- “it’s difficult to compare qualitative...” – what have we really learned? The points don’t answer the question
- Remember people read the first two and last two bullets, so those need to be done well
- Give examples of the TYPES of evidence needed, criteria, etc.
- Include links to examples, if not examples themselves (ie, links to projects on CIHC site)
- Add quotes from students, practitioners, etc.
- It doesn’t seem like the evidence backs up the outcomes you cite?
- Ignores the fact that the studies have very little evidence (ie, 5 of 6 report positive learner focused outcomes – the only study not listed is the one characterized as robust (table 5)
- Consider making a two-pager out of this
- Should there be different documents for different groups?
- Need a clear description of what IP behavior looks like, particularly for those trying to educate undergraduates.
- The document highlights a potential disconnect between the clinical and academic worlds.
- Why not describe how to DO IPE
- Perhaps some ‘boxes’ that highlight key excerpts from the synthesis would be helpful
- Provide better information on how to conduct studies, give methodologies so people can begin to understand how they can contribute to the body of knowledge
- Add a piece on “What is being done currently”
- How are students practicing in clinical areas? Include this evidence

- What do patients tell us? Is this not coming through or not being measured?
- Need to figure out how to supplement this document with regional information
- Describe what we need to strengthen the evidence base
- It looks discouraging, and like nothing has been done (no evidence, what about our project?) This really highlights the need for some local information
- Who is this document for?
- Strengthen the recommendations
- Don't be so 'married' to research
- In synthesizing, the information has become too general... so what now?
- Mention that CIHC is working on common competencies
- Are we talking about IPE or CP?
- Is this about HHR shortages? (Problem oriented) or patient-centred care/team satisfaction?
- Building a better collaborative environment is the goal. Why don't we say that?
- Right up front show the linkage IPE – CP – CPP
- "What can I do to help promote IPE?" show concrete actions
- How do we convince professionals "will I want to work in an IPE setting"
- Include more success stories
- How will this affect me (the practitioner) or me (the client)
- Practitioners need to know someone else has been successful
- Want to know about cost
- Stop saying we aren't doing well enough
- Does IPE lead to better practice?
- Equally or more important to decision-makers is evidence from the practice environment
- Regulatory voices need to be heard (the collaborative voice would be better)
- How do we use this to influence governments on a provincial and regional level?
- Also need to include accrediting bodies
- Would like to see evidence that demonstrates practice leads to better outcomes
- Collaboration does not really help HHR shortages – it would be better to look at effectiveness and efficiencies- not put it in the context of the shortages
- We have evidence about what goes wrong when people don't work together, how is this incorporated?
- Need to figure out when it is most important to work together - IPE is not always needed

FAQS

- Why need to talk about interdisciplinary vs. interprofessional? Old news. The definition is confusing. “I thought I knew before I read the FAQ and now I don’t know anymore.” “Who cares so long as people are talking about it?”
- What is up with the air traffic controller reference? That’s not something most people in healthcare will ever relate to, take it off!
- The HHR stuff is poison, will make groups defensive. Some feel that interprofessional alludes to replacing existing health professions. Others that it suggests some need to communicate better.
- Need to address “When is IPE/IPC appropriate, because it isn’t always, make that an FAQ”
- Does IPE take more time?
- Answer to #4 doesn’t answer the question
- End of #4 “evidence makes the best case” is inconsistent with #1.
- #5 how does IPE benefit patient care? - answer is trying to talk about the system, stick to “improving workplaces”
- Add a question re “turf issues/replacing health pros with other health pros”
- #7 contradicts #4
- #6 is very useful and should be expanded
- #8 – narrative doesn’t address the question
- Is it worth the cost? (peoples reactions to IPE/IPC is not sufficient)

Appendix B – Focus Group Attendees, By Location

Toronto, Ontario – Facilitated by Dr. Scott Reeves

Alex Harris, Practicing RN, Former President of the National Health Sciences Students' Association
 Ann Russell, Director, Centre for Learning and Innovation, Michener Institute
 Deborah Kopansky-Giles, Coordinator Integrated Care, and Care Research, Canadian Memorial Chiropractic College
 Heather MacPherson, Chief of Health Disciplines/Director of IPE, Women's College Hospital
 Kelly Stadelbauer, Executive Director, Association of Ontario Midwives
 Lianne Jeffs, Director of Nursing/Clinical Research, St. Michael's Hospital
 Renee Kenney, Dean of Health Studies, Centennial College
 *Andrea Burton, Communications Director, Canadian Interprofessional Health Collaborative
 *Joanne Goldman, Research Associate, University of Toronto

Saskatoon, Saskatchewan – Facilitated by Andrea Burton

Carol Henry (Chair ICEC4: cont education)
 Carol Klassen, VP Knowledge Management and Strategic Development, RQHR
 Donna Brunskill, Saskatchewan Registered Nurses Association
 Jim Greer (Director of University Learning Centre, representing Vice Provost)
 Joyce Butler, Primary Health Care Development Consultant for Marci Scott RQHR
 Karen Eisler , Director of Nursing Practice, Saskatchewan Registered Nurses Association
 Kevin Veitenheimer - Advanced Education, Employment and Labour
 Nora McKee (Chair IP Vertical Theme Committee: College of Medicine)
 Peggy McLeod for Lorna Butler (Assistant Dean of Nursing, University of Saskatchewan)
 Sandra Cripps, Saskatchewan Government, Workforce Planning
 Sheila Achilles, Director of Primary Healthcare, Saskatoon Health Region
 *Liz Harrison, P-Cite Project Lead
 *Leane King, Saskatchewan Academic Health Sciences Network

St. John's, Newfoundland – Facilitated by Andrea Burton

Patti McCarthy, CCHPE, Memorial University
 Daphne Robinson, Manager, Learning & Development, Eastern Health
 Mary Manojlovich, Regional Professional Practice Consultant, Occupational Therapy, Eastern Health
 Debbie Kelly, School of Pharmacy, Memorial University

Colleen Kelly, Nursing Consultant - Education, Association of Registered Nurses of Newfoundland and Labrador

Doreen Neville, Vice President – Academic, Memorial University

Bev Clarke, COO – Community & Children, Mental Health / Addictions, Eastern Health

Shelly Birnie-Lefcovitch, Director, School of Social Work, Memorial University

Gerard Farrell, Assistant Dean, Faculty of Medicine, Memorial University

*Dennis Sharpe, Co-Director, CCHPE, Memorial University

Winnipeg, Manitoba – Facilitated by Andrea Burton

Brenda McKechnie, Registrar for College of Physiotherapists

Gustaaf Sevenhuysen, Dean of Human Ecology, University of Manitoba

Jan Currie, VP and CNO, Winnipeg Regional Health Authority

Jerry Ross, Executive Director of Workforce Policy and Planning, Manitoba Health & healthy Living

Josh Watt, Program Analyst of University and Colleges, COPSE

Kathleen Klassen, Manager in Nursing, WRHA

Kurt Schwartz, Representing Spiritual Health at Health Sciences

Tony Iacopino, Dean of Dentistry, University of Manitoba

*Ruby Grymonpre

+ Dean Collins made introductory comments

Vancouver, British Columbia – Facilitated by Andrea Burton

Andrea Dykstra, Midwifery Student, University of British Columbia

Ethel Frankel, Consultant, Former Executive Director of HealthMatch BC

Lesley Bainbridge, Associate Principal, UBC College of Health Disciplines

Jason Nickerson, National Health Sciences Students' Association

Joyce Black, Education Consultant, College of Registered Nurses of British Columbia

*Brenda Sawatzky-Girling, Managing Director, Canadian Interprofessional Health Collaborative

*Individuals marked with an asterisk were part of the organization and facilitation of the focus group

+ Dr. Collins made introductory comments, but was unable to attend the session

Appendix C – Transcription of Key Discussion

Each of the five focus groups was recorded digitally in order to ensure the conversation could be accurately captured for this report. This appendix captures the key comments made at each focus group. On the rare occasion that a comment was incomplete or inaudible, it has not been included in the transcript (this would amount to an average of two comments per focus group).

Please note: some of the opinions expressed during the conversation were not necessarily shared by all participants and may have only been stated by one person throughout the course of the entire project. These comments are included, but do not necessarily reflect the opinion of the CIHC and its members or other members/attendees of the focus group.

Where a response was required from a facilitator, co-organizer or author, it is indicated by [-].

TORONTO, ONTARIO

- One of the first things I noticed about the Evidence Review is that it's not as action-oriented as it could be. A lot of the language suggests "generally well received", "Potentially", "possibly. I think it's well written, but I wonder if there's a way to use more actionable language. I know you can't say definite things because researchers take issue with that. Like even "IPE has the potential to..." is it too much of a leap to say "IPE can...?"
- Who is the intended audience? A broad audience or those who already work within health care systems who have an understanding of interprofessional education and collaborative practice?
- [The document is for anyone who's a decision-maker or might be doing something with IPE, it was arranged to be a quick read. If someone is interested in looking at the details they'll go ahead and read the longer report. So this Evidence review was for an introductory/general audience.]
- Is this just the Canadian scenario, because I know there's a lot of work that has done in the UK? [No, this information, and the six reviews, are all part of the global literature. In fact, a large portion of the Canadian scenario – outcomes of the IECPCP projects – was not included because final reports had not been submitted at the time this document was published.]
- Is there a reason why you're not using the new WHO definition that came out in 2008? [While the WHO is set to release a document on Interprofessional Education and Collaborative Practice, the document has not been officially released as of yet, and as of the publication of even this report on the focus groups, has not been released. Additionally, the WHO definition is not new, it's a minor clarification of the WHO's interpretation of the CAIPE definition, which is the definition CIHC uses for interprofessional education.]
- I found the documents all very easy to understand as far as the wording went. What we need to do is strengthen the evidence, so I would agree with the comments that it isn't strongly enough worded.

- It's a clear read, but I'm not sure it tells a compelling story. If I wanted to learn about how to implement this in professional practice, it doesn't actually tell me why or how I should do that. If this is for decision-makers to help their understanding and get them started towards building the case for interprofessional education, I'm not sure this would make the case in any way other than to suggest it as a possibility. I don't think they'd know what to do with it though, it would be a 'so what' moment. It would be nice if there was one definitive statement about interprofessional education. I understand it might be early days, but if there was one statement it would make this whole thing seem stronger. Otherwise you're saying "we want you to do this, support this, believe in this, it's great – oh but we can't prove it".
- I know that you're focusing on interprofessional education, but you have a sentence that talks about how interprofessional education is a potential solution for the healthcare system, and I would argue that this is entirely untrue. Interprofessional collaboration or interprofessional practice, whichever you call it, that's a potential solution for the healthcare system. We can't really know about the outcomes of interprofessional education unless we measure what it does in the practice setting. It would strengthen the whole thing to say that the underlying reason to do interprofessional education is so people can practice more collaboratively.
- You talk about how you would like to demonstrate the impact of interprofessional education. On what? Systems? Clinical Practice? Planning? The price of gas today? Needs to be more specific. What is the overall goal of interprofessional education?
- The order should be looked at. Rather than defining interprofessional education first, maybe the first sentence needs to catch the reader's attention "There's a worldwide shortage of health care providers which is why this is becoming important – interprofessional education can help address the shortage". Explain why this should be the new thing that government's are looking at. What we've learned about how it's viewed can go later. If you read that it has the potential to improve practice first, then you're more inclined to read on. If our organization was to share this, it would need to be stronger that way.
- The whole tone of the document is so depressing, it just doesn't sound very hopeful. It's very scientific. It's written very well, it's not about the writing. It just sounds sort of negative and scientific. It's not very compelling politically or in an environment where you would sway people. How can you sway people when you're saying "well we're doomed, we have no evidence".
- Having just come out of a major project that we did, I think it would be good to say that evaluation of interprofessional education requires qualitative and quantitative evidence, not just go to the statement that it's "difficult to compare qualitative and quantitative data" which is kind of lame, and actually not true. I would write that piece differently. Maybe pull qualitative and quantitative out separately. A lot of people don't believe in the strength of qualitative research so it would be nice to strengthen that on its own, because as policymakers, we actually DO rely quite a bit on qualitative data. We like stories too!
- I'm wondering about linking it to other things. I know the focus is on education but the goal is interprofessional collaboration and good patient outcomes or patient safety.

When you think about all that it isn't reflected here. I think linking it to some of these other areas would be good.

- You could add another page and make it about interprofessional education in the real world. This is what it looks like, this is how it works. Somehow you have to link this to interprofessional collaboration or it falls short.
- [What's the acceptable length for something like this?] Two pages max, nothing more.
- The tagline "now is the time to get involved" implies that there's going to be encouragement and motivation in here, but I see nothing in here that answers the question why? Why is now the time to get involved? Where's the thing that will make me think "yes yes, get involved!"
- Have you considered using quotes? Students, practitioners, or something like that, someone who's doing it. Use quotes from the qualitative work you've done. Quotes are very powerful.
- I thought it was lovely to read, really well written. But I'm not sure about what group you're targeting. I'm not sure I can make any decisions because it's ambiguous. The clarity was really nice though.
- I can imagine it being useful in so many ways if it was accompanied by supporting documents. It would help me more to hand out the whole document not just the one page. I think it's incredibly useful and a worthy pursuit. I just wouldn't leave it at one page. Use it as an overview/synopsis, but make sure the rest is there. I would want to know, as a researcher, what are you basing this one page on? So give me the whole thing, at least give me access to it. Prove it if you're going to say it.
- Is it necessary to have the definitions on the main page since you're so limited for space? I might use the real estate for something else a bit more useful – a quote or whatever.
- In my department people are already on board with interprofessional collaboration, but in those programs where people are not as involved... for those people who might need support in their IPE activities, this could be helpful. For departments that are struggling, this is important. And you need a one page summary to accompany the longer document, because some people won't read the longer piece unless they have a lead in first.
- I was going through some of the projects on the CIHC site and it's quite tedious to go through it all so I wonder if you could group things on here to have some outcomes or something. I'd like to have had a summary of those projects, even in terms of grouping some of the findings and outcomes.
- Is there a pressure somewhere that can be solved by collaborative practice? Something like the Electronic Health Record, because if you could tie all of it in to something like that, people would relate to it. When I was at McMaster one summer, we had one set of notes, and we all got to read what everyone wrote, and that was the time I most felt part of a team, when I knew what the doctor wrote, what the physio wrote, what the dietitian wrote – and it was all just equally entered. So should this be pushing and causing some pressure to the system to change in that way? Because I think that practice hasn't changed that much. I feel very disappointed that I graduated in 1964 and

in 2008, things haven't changed that much. I'm hopeful that this interprofessional work will help to make a change in the system.

- We're seeing changes in primary healthcare and integration in services, but we're lagging behind in infrastructure. At the upper levels we're not encouraging collaboration at all.
- What we need to strengthen the evidence base for interprofessional education, rather than making it research focus, is to make it decision-maker focus. What do we need to know to make decisions about clinical readiness?
- You could make the point that qualitative is as useful as quantitative, and in some ways more interesting because it addresses the attitudes and perceptions of people. And isn't that what interprofessional education and collaborative practice are all about?
- Also would be interesting to look at 'what are the drivers' (ie this needs to change and that needs change). What is driving the political agenda?
- I don't know what it is, but font makes a difference to me. This is Times Roman and I don't find it an open/welcoming font. I find this too formal. A more open and progressive font would make this seem like a much more approachable document.
- I would like to see a document created with a slightly different focus. If you look at the whole document it's talking about the evidence, where we are with the evidence, the quality of the evidence and what it means. I don't know if this was just supposed to be talking about the evidence, but now we're saying we want it to link to the real world, we want it to be clinical, we want the political messages, we want all these different things, it needs to be formatted and formed differently. Looking at the FAQs, I like how there's headings, it draws your interest and you can click for more information. So if somebody was looking at this, if you just gave it to anybody, they could be people involved in faculty development, they could be involved in curriculum development, they could be practicing – a whole slew of things – so we need something where we talk about what interprofessional education is and how it's linked to interprofessional collaboration, and why that's important right now, then talk about where the evidence is, where we need to go, and why we need to get people involved. And after that, we need to include specific links for people, so if someone is reading this and all they care about is faculty development, there's actually an area where it says "this is what's happening in faculty development, click here for all of the CIHC/IECPCP projects that have something to do with that", etc. In other words, target specific groups just with a link, so you don't have to go through every single project if you're interested in one specific thing.
- Target special interest groups/audience. You do that when you talk about decision-makers, students and clinicians, but what you aren't answering is, why should people get involved? Make that argument explicit through the use of evidence and summary to those three groups.

[This document aside, what materials could CIHC develop that would be useful for you in your role?]

- Competencies. There are published competencies, UofT published theirs, and CIHC is pulling together competencies, so that will come out before too long, but that's a key

for us. That will make a big difference to the work we're trying to do, or should be doing.

- However you generate evidence (synthesis, research, pilot projects, etc.) , produce fact sheets that we can use when we go to whoever holds the money and use in part as evidence and proof of successes. We need the short and dirty. We need more stuff like this. But with compelling information on it.
- Bring in some of the peripheral groups and linked content such as the Canadian Patient Safety Institute which has come up with patient safety competencies that are interprofessional in nature. In other words, leverage other partnerships.
- Develop a joint statement with some of these other organizations on the importance of interprofessional education and collaborative practice. You have the article in the newsletter with David Butler-Jones, but you could take that further and actually have a set of joint statements from prominent healthcare leaders. That would be meaningful and useful for us to have. You could put it on your website. Kind of like "Advocate Quote of the Day" or something.
- Start talking about some of the promising practices for collaboration. That term resonates in a healthcare environment and academic institution. It may be one off's and that's ok, but where you have a best practice where a team was able to change a patient's outcomes around best practices in interprofessional collaboration – tell us about the collaboration and tools used to. We often get overlays of initiatives and then we have to ramp up for something different – safety, wash your hands, etc, these are all good things, but we overlay them instead of integrate them, and we need to integrate them as building into safety, evidence that interprofessional education works. Why has it been successful? We need to do a better job of not coming up with one-off campaigns that we overlay, but rather integrate the campaigns we run.
- Get a bank of experiences. At a faculty development workshop I went to, the information that really interested people was 'what have you done, how did you do it, did it work?' People want to know what's out there that's working so long as it's a structured program that's had some evaluation. If you can do that, I can maybe adapt it to my situation. Because interprofessional collaboration, at least in my department, is on top of everybody's job. It's not like anyone has time to do this, it's just expected because we teach in our department. People want to know what's been working in other environments. We hear about UofT, but we don't hear about UBC and Ottawa and Queen's and what's working there. We need a better way to hear about that stuff. A better way to share. [The CIHC Library, which is up and running, but still not well-populated, will eventually provide much better opportunity for that.]
- Accreditation Canada is a good link because they go in and are looking at standards in interprofessional collaboration. We need to connect with them.
- Say something to MOHLTC in Ontario and say they should share the research that they gave all that money for. We informally shared our projects and what we've been doing, yet we haven't felt really free to share the Ontario stuff, whereas with Health Canada it gets posted once we submit it. We have no idea why Ontario is holding our reports and outcomes close to their chest. Everything seems to be secretive about the ICEF stuff.

- Would love to see a conference on this where success stories can be shared and pressure can be brought on decision-makers. [Note, OC had a conference in January of this year, Halifax in May 2009].

Toronto List of Ranked Priorities

1. Stronger Language & Fix Title
2. Link to Key Issues in Healthcare (context)
3. IPE to CP Connection/Linkages
4. Answer question 'Why'?
5. Be more directive "go to report"
6. Provide ideas about what to do with this sheet
7. Political messages - how would you use this information?
8. Link to further information targeted to specific groups
9. Use quotes
10. National & Regional version
11. Go to two pages
12. Move the 'impact on practice' bullets to the top of the list
13. Make definitions smaller, or move elsewhere
14. Equal emphasis on qualitative and quantitative evidence
15. Funding discussion
16. Change the font to be more open, progressive

SASKATOON, SASKATCHEWAN

- When I read the documents, the one thing that comes to mind has to do with (and I feel like a broken record), the application of theory to practice. A statement like “unfortunately there is not a lot of evidence...” seems so negative, and yet if it’s true, that’s a problem. We have some really good projects out there we can point to, but building a stronger evidence-base (more examples) that points to better outcomes for the people we care for, that’s important. Why are we not using the evidence we do have? For instance, the Saskatchewan project data? [Note, that information had not been compiled/evaluated/submitted when this report was published]
- Can we not separate quantitative and qualitative data? It would be interesting to see what we’re finding in quantitative and what we’re finding in qualitative. I think we need to see both. One of the concerns is finding funding for long-term studies that pull together the quantitative data.

- This is absolutely excellent that you've put this piece of work together because it's really important. In a strange way interprofessional education has become the buzzword, and yet as you go through the FAQs, I start to wonder if we're having the same conversation but many conversations all at once. I think anything we can do to actually give a sense in terms of what we know and what we believe, based on the research and evidence to this point can help guide how we prioritize and how we go forward in the next opportunities. It certainly is of interest to the region if we do a good job academically of creating an interprofessional focus, but are not carrying that forward to our workplaces? Are we having a receptive response to team-based workplaces? If not, we have some challenges in terms of how interprofessional education links with the delivery of care and the quality of patient experience and safety, even if we know for sure it works in some specific places. Knowing this information can help us figure out where to make more choices in terms of interprofessional education in the future.
- I really think that the sentence about how difficult it is to compare qualitative and quantitative data, should be taken out. Really you shouldn't compare these two things because the criteria is different. What we need to do if we have qualitative research is highlight it and not compare it to the quantitative. We need to look at this and highlight it and not just rely on the quantitative. Can we highlight the qualitative research? That could help to drive the momentum.
- By its nature this area requires a lot amount of faith initially to go forward before you're going to see demonstrable gains. That's where we're at right now. There is a potential disconnect between what we see in the academic world and what we see in the clinical world. This is a problematic area, and one we can't address without evidence, unless people have that sort of faith to begin with.
- It's not even just faith. We need to have champions if it isn't happening out there, especially if people are trained to do it and still aren't doing it. So we need to have champions in the facilities or RHAs or it won't progress.
- We need champions in the practice setting, communities, facilities, but we need more than just champions, we need the ability to evaluate what is actually happening with interprofessional teams interacting with practitioners. What is the actual outcome? We have almost no tools right now that are useable and manageable. It's very frustrating. We don't have the time or money to evaluate what's going on in the practice settings where we think interprofessional education and collaborative practice is happening. I think it is happening out there, but we don't have the ability to do a good evaluation. We have some good team effectiveness tools and other things, but we need something at our fingertips that will work. We need to connect the education and practice setting better.
- It would be helpful to have some key things pulled out of the synthesis review, so I have an understanding of what has been done, and what the gaps are. It would help to have some actual examples of that, so I have a better sense of what's there.
- When we're trying to graduate undergraduate students one of the things that needs to be clear to the students is how they have to behave, what are the knowledge and skills we're working towards. I don't think we have clear descriptors of what their behavior should look like. We need something that works, something that shows the students

that they're reaching the bar when we're trying to teach them. We need to describe better what it is we want the students to aspire to. I'm not sure if it's this sheet, but it's important and something we've asked for, but no one seems able to produce. So I'm raising that to say... put it on a sheet like this!

- I'm curious to know if there are any research studies done locally that have contributed to this body of knowledge or are we drawing from external sources? [Projects done in Saskatchewan hadn't been published when the synthesis was done.] There is local evidence to contribute to this and for me then, one of the key things would be that people need to have an understanding of how to conduct small and valuable studies that are really practical in applied settings around program evaluation generally and this is something that anyone involved in delivering program needs to be able to do from this assessment and have little methodologies for doing this assessment that can contribute to the body of knowledge and that can be quickly and cheaply implemented. We talk about needing a lot of time and money, but a number of program evaluation methodologies don't need time and money, they need someone with committed time to gather the data and do the design and analyze it. We need to identify how those things can fit in with the daily work done in the practice settings. That would be vital.
- I'm pleased to see there's been work done locally, but could there be a toolkit created or a set of instructions and methods on how to conduct research to be able to bolster up the global work that's been done? If CIHC created a standard set of evaluation questions for all of these projects for instance, would you not start to collect some data that would help to answer some of these questions? Rather than a big research study, if the people leading the project could each provide answers to 100 common questions about their project... you'd have some results I think.
- Perhaps one of the gaps is that we don't see the local piece in here and without it we may be finding this misleading because there is a lot currently being done it just isn't in this synthesis. So the piece missing may be that if someone was to pick this up, maybe there's nothing about 'what is being doing currently that will help us to inform. That is especially true for policymakers. It seems a little like "oh we've done this synthesis, we only have this" when in truth there's a wealth of info out there, it just hasn't been published yet. I wouldn't want a policymaker in Saskatchewan to get this by itself and be like "man, there's nothing on this yet eh?"
- Some of the evidence that we might need really relates to how these students are practicing in the clinical areas and are they practicing collaboratively? Are they practicing interprofessionally? How far does the interprofessional education really go? For me it's the evidence that they're making a difference in the clinical area that would be beneficial. Are they taking an interprofessional approach and what do the students tell us about that as part of their education experience? In my view that's a key stepping stone to interprofessional practice and as an interprofessional practitioner after graduation. And I haven't seen evidence that tells me the students are practicing collaboratively and interprofessionally in their clinical experiences. And what do patients tell us about the experience? That's not coming through. Is that because it isn't being measured or there's nothing yet to measure?

- Also it would be good to see if the students' interprofessional education is influencing the profession and attempting to change the way they practice. This is a research agenda – a bunch of research that needs to be done. A lot has been done and is synthesized in here, and this is a meta-analysis of this. There are dangers in that, it doesn't answer specific questions, only general, overall understandings. But I think that targeted and specific research that addresses regional and individual program needs to be here and should be the supplement that's put in here. I guess we're beginning to do that. I see you at this table and on the phone setting a research agenda. How do we support that?
- Perhaps what we need to do to strengthen the evidence-base for interprofessional education is to strengthen how the research agenda is formed. Are we actually asking policymakers if we're on track with what we're researching? Or are we going ahead and doing the research that we think needs to be done, with no links to the policy side? There should be some fill-in related to the activities that are going on in the regions. Maybe this is a supplementary document to what is happening locally. If we are doing things 'at home' we need to highlight that.
- We need to make sure that when stuff is published we get it out there, because otherwise it looks discouraging and like we haven't done the work when we know that Saskatchewan has done a good job of doing research.
- We made a concerted effort to join the academic and practice world on our P-CITE project, perhaps more than any other project that came under the IECPCP. In every single meeting we had both the practice and the academic people, and we didn't focus on one or the other. "This is a provincial concept but not an academic one". This made it hard to manage, but worth it in the end in terms of the amount of research and success of the projects we had. Some of the work was so practical and we have excellent outcomes, right here in our own province.
- It would be valuable to date this version of the document, and then do several more of these, as more evidence becomes available. This becomes the baseline Evidence Review.
- We need to bring out the practice side more. It's just not there, and without it, it's like we're trying to say "you should teach your kids the alphabet", without mentioning that the goal is for them to read. So interprofessional education is learning the alphabet, but when you learn how to use the alphabet, then you're actually putting it into practice by reading.
- Generally I'm hearing people say "get this published", but what about waiting on the results of the projects? It's a good question because it leads to the question of what kind of format we want to go with. There are detailed reports that are being sent to Health Canada, but that is a separate thing, this is more of a knowledge exchange piece, not an evaluation piece. It's back to the communications people how you can use the information that you have.
- Who is it for? Strengthen the part at the end, because when I got to the end I thought "so what now"? I didn't feel this fact sheet was strong enough for decision-makers/policymakers. I wouldn't look at it now and think I could use this. I don't think there's anything here for action except "Researchers should" I'm not sure it will get anyone else involved.

- There's a battle between the communications person and the researcher, where the communications person wants to make sweeping, broad, definitive statements, and the researcher is saying "well we can't say that definitively, but maybe we can say that it might be possible to perhaps think we could somehow". So this is defeatist language, but as researchers we don't want to make any really definite claims if we don't feel they are easily defensible. This is why we need spin doctors.
- When I look at this, I really like the fact that a document like this has been put together. I struggle wearing a decision-maker hat as to what this prompts me to influence or put on the priority agenda for our organization. Interprofessional education is a key part of what we're trying to foster and promote, but the part that's challenging is that in synthesizing information it's become so general it's hard to know how to prioritize it to apply it to the next steps. So what now?
- When I read through it, the piece of information I would add if I was pitching it forward, would be to reference some of the P-CITE examples in terms of 'know your audience and the picture you're going to give'. This would be something I could take in companion with that. This is one piece of it, but here's what Saskatchewan has done, and use those as stronger references. Use this, but put on the backside, the Saskatchewan focus and content. I could speak to that more, and I would then lean on that a lot.
- It needs to be mentioned here that CIHC is working on common competencies because in order to measure anything you need to know what you're measuring. You mention the skills and competencies necessary, but that might be worth mentioning as well.
- I find it interesting and exciting to look at info like this to hear what has been done that I might be able to do as well. What can I implement in my own experience? So even if you had said a few things like 'here are the kinds of things that have been done' or 'this group used an attitude scale', then as a decision-maker I could say "well geez, it would be easy for us to do an attitude scale". This is very general. It doesn't have to be already proven, so you don't drive the researchers crazy if you put it in, but just give ideas of what could be done to evaluate interprofessional.
- In the second paragraph I struggle with the phrase "health human resource planners... have come to recognize that appropriate interprofessional education may be a strategy in managing health human resources." I wonder if it's really interprofessional education or is it collaborative practice that is a good strategy? And I wonder if focusing on the HHR shortages is really the key phrase or are we really looking at collaborative practice in terms of better patient care and better outcomes. If we're looking at shortages it seems so problem-oriented and doesn't seem long-term or future oriented. What we're talking about is interprofessional education as a component that will get us to collaborative practice and the whole reason we want to do that is better outcomes for patients. That sentence is too narrow.
- Team satisfaction is important. If people work better as a team, they'll stay in their job, and patient outcomes will be better. That's what we're trying to sort out.
- Even if patient outcomes don't change or improve, but you have more satisfied teams, or more collaborative teams who were delivering the same level of care, that would still be a win. It's ultimately about the patient, but there's an interim step here too. Hoping

for improvements in patient care is optimistic but possible. But you don't have to pin everything on that, you can actually hope that more efficient and effective system with a more collaborative environment is a win.

- Interprofessional education as a strategy to address HHR shortages, that doesn't connect for me.
- It seems to me that maybe an upfront piece should show the pieces of what this is. This is about interprofessional education, but there are other parts to this that are necessary to make it work. Right up front you have to say that there are linkages. Interprofessional education to collaborative practice, collaborative practice to patient-centred care, etc. We don't have the practice piece yet, but maybe we can say "this is the interprofessional education piece, and now we're moving on to the collaborative practice piece" because they have been treated independently and that's not quite right. We need to move to the practice setting. We have to start somewhere so maybe interprofessional education makes sense, but we need to preamble this by saying it's not the be all and end all.
- It says "now is the time to get involved" and I think "with what? Who?" There are a lot of comments about interprofessional education having the potential to do things, but if there's evidence that it's gone beyond potential, you need to say that. No more wishy washy language, be very clear. It sounds like there's more than potential. We know even just here in Saskatchewan that it's doing that, so say that. It's that researcher language again.
- This kind of minimizes results. Our results in Saskatchewan may not be impressive enough for people in the research community, but this seems to downplay anything that isn't a big international study. It makes it seem like it's unimportant if it isn't part of the big world research agenda. That's offensive. The local results are actually probably more useful to us than the world results.
- We need a tool to go to funders and they want to know what the cost is. But once we get the funding and we go out in the community to work with practitioners, how do we convince them that this will be good for them as a professional? How will it change my practice? Will I like it? Convince me that I'll want to work in an interprofessional setting. We need to build that capacity at the front end.
- When we come in with a change, people always say 'how will it affect me?' There are two 'mes' here – me the practitioner and me the client, and we need them to think about both mes and move away from how does it impact me as the provider. So any success stories we have where we can highlight that, will help a lot. Practitioners need to know someone else has done this successfully and what the benefits were.
- I appreciate the recognition that educators are on board with this and now we need to move to get practitioners involved. How do we embrace the students who have done interprofessional education? Is there a way to follow students when they get into the real world, learning if they're still practicing this way (or more than other practitioners)? If we could make that link it would be huge.
- There's always great sensitivity when you go in to improve something, people think "are you saying what I'm doing isn't good enough?" We need to be really careful about how we sell this. Our practitioners are fabulous and doing great work. It isn't about better,

it's about doing things in a different way – more cost efficient, more streamlined, whatever. Don't turn people off by making them think we don't believe they're doing a good job already.

- What we're talking about is research into practice and there are a number of frameworks we can use to do that. The Saskatchewan Registered Nurses Association could use this for communication – to create awareness for members, and then hopefully change the behavior. We have a lot of the facilities to do this, to get to members, we just need to get the information to the members and then let them go ahead with it. In addition, the provincial mentoring program could actually have students mentoring mentors on this kind of thing, on their behavior. That would be huge. The SRNA could also lobby for support of this, but we need to know does it lead to safer practice, does it lead to collaboration etc. That's the kind of information that would be very helpful.
- One of the most compelling reasons for interprofessional education I've heard was from a long-time practitioner who is now an educator. We were talking in a group about our problem-based learning modules. And we have all health science students involved and we were talking about how sometimes the students don't see the benefit, "why am I here and how will this help?" She told a story that the only way they made any real progress in a wound management effort they'd been trying to integrate into the health region for years and years, the only way they made the giant leap into the current really good practice was through a team. And how they formed the team that was interprofessional worked for the best outcome she thought they'd never reach. That's the kind of story from practice that would interest and compel people. It also helped us as educators to reinforce why we think this is important to our undergraduates.

Saskatchewan List of Ranked Priorities

1. IPE = CP = Improved patient care - add this to the preamble
2. Concrete actions
3. IPE is more than Academic - enhance the professional practice aspect
4. IPE is not a strategy for HHR issues (rephrase)
5. Give examples of research ideas
6. Rephrase/rework "what we have learned"
7. Who is the fact sheet for: define audience
8. Rework ending (strengthen practice setting)
9. Highlight local activities
10. Needs a tool with clear recommendations or steps
11. Use it as 1 piece, but recommend users add specific info for their own audience
12. Heading "now is the time... involved" is disconnected to the content - remove

ST. JOHN'S, NEWFOUNDLAND

- My experience trying to get an Interprofessional college off the ground in Newfoundland, is that we need evidence-informed decision-making. This report just talks about evidence from a research base. But for decision-makers it's equally important to have evidence from a practice perspective. A brief story, I was talking to the Minister of Health recently, and doing my usual, which is usually about three words of hello and then I launch into "about the College of Interprofessional Education..." So he sees me coming now. His eyes were glazing over and the Dean of Medicine stepped forward and said "actually Minister, it's really important and we're going to have to try to focus on this more in the future" and all of a sudden the Minister's interest improved again. Now he's an excellent Minister, and I'm not complaining at all, I'm just saying that for us to come at it from an academic perspective is not always as important to the decision makers as if they hear it from the nursing association or medical association or deans of the schools. If those people are saying "By the way this is as important as..." That gets the attention of decision-makers.
- A lot of work needs to be done on working on outcomes and that kind of focus, but also more testimonials from people in practice and the real world about how it really works and how effective it is. It's still important to have the research/evidence-based, but where does this sit on the priority list in comparison to things like increasing the number of nursing seats or expanding diagnostic capacity or whatever? I really think this is a high priority but getting on the political agenda is different.
- Regulatory associations and professional associations do support this and I think many are stepping up to say it's important. However, I think there needs to be more collaboration between us to really get this on the agenda. One of the key components of primary health care is interdisciplinary practice and you have to have referrals between professionals without one professional as gatekeeper. If you have associations or regulatory bodies working together and supporting the key principles of interprofessional education it would make a strong voice for educating members and stakeholders. Any one group going alone won't work. The collaborative piece needs to be there.
- How as associations do we position ourselves to be influential in supporting interprofessional education? This was discussed at an occupational therapist/physical therapist/speech language pathologist session in Toronto in November, because one of the issues is that associations are working together, but since the primary health care funding is no longer available a lot of projects and groups have dropped off. The point of the weekend was figuring out how to get on the agenda, be political, get the media, etc. It's important, but it doesn't always come together – we aren't always sure how to influence government at the provincial and federal levels.
- We really relied on the primary healthcare funding to do interprofessional work and since the federal funding has dropped off, the province has really dropped the ball on it.
- The accrediting bodies really need to be at the table as well. Speaking from an academic perspective when you're talking about juggling the discipline-specific issues that have to be covered in curriculum and you're trying to fit in these interprofessional pieces, it goes a long way when the accrediting bodies recognize that there's more than one way

to teach material and there are benefits to teaching students from different professions the same material or pieces of the same material together at the same time. In the early days of pharmacy at MUN, a lot of times Pharmacy students were placed under physician supervision for practice experiential placements. The school was chastised for that. Pharmacists should be trained and mentored by pharmacists, etc., etc. Well now there's been an about-face and the new accreditation guidelines we're expecting in the next year are recognizing that having these interprofessional placements, not just where there's a pharmacist supervising pharmacy students but actually placing students in environments where they typically aren't already practicing, ie under the mentorship of a nurse practitioner, physician, etc. is not just an acceptable way of getting a student placement, but is in effect, a valuable learning experience. Accrediting bodies need to recognize this is a valuable thing to do. It's not a band-aid to fix the problem of not having enough placements, it's actually a direction we want to go in.

- What evidence do we think we need to support interprofessional education? And I would like to see evidence that demonstrates that interprofessional practice leads to better outcomes. And also that interprofessional education leads to better interprofessional practice. And then some kind of path analysis that shows that interprofessional education ends up or contributes to improvements in outcomes. I think that's a level of analysis that's needed for people to argue in a very compelling way that interprofessional education is something we ought to be making large investments in as a post-secondary institution and that organizations/agencies that are delivering health and community services should be organizing themselves in terms of delivering interprofessional practice. I think that's fundamental and that's what we don't see in the literature to a great extent. We get lots of intuitive ways it makes sense to all of us, but we need to see it in a tangible way. Some of the stuff we're seeing says it takes more effort to get people to collaborate than is worthwhile and it doesn't improve shortages or anything.
- I think we should look at issues of effectiveness and efficiency and not frame this discussion in the context of shortages.
- I agree we don't have research in terms of outcomes, but we have so many examples where what we're finding (and you could look at places we've made errors in the past), is that one of the primary reasons the care people received is not what it should have been, is that people didn't work together. And that's because we do work in silos. And whether it's breast cancer in Newfoundland where everyone worked in silos and didn't see the big picture, or it's a child custody case where mental health, social work, and legal didn't work together on the big picture and therefore didn't make best decisions.... Whichever way you look at it, we have overwhelming evidence of when we didn't do it right.
- We have to figure out when it's appropriate to do interprofessional practice. Every patient/client/resident that we see does not need an interdisciplinary team and model to move them forward. But there are some critical examples where that team is really important. It does provide better outcomes when it's used appropriately, so we need to figure out when it's most appropriate and give people some guidelines around that and make sure they're doing what they need to do. It isn't every client we see, it's complex

cases. I think there's lots of evidence around what we haven't done right. Maybe we can learn from that.

- The problem with getting outcomes from the long-term perspective is because of the resources you need to do the work, we apply the model conflict to everyone, and everyone should be in teams and they're all going off to do their work, and then when the funding runs out, everything shuts down and the momentum isn't there to continue it on. I'd like to reframe the question around what is the evidence we have that supports collaborative practice within the context of those cases that need it where appropriate. And maybe we have evidence that points to that.
- The evidence is there that we need more collaborative practice, that's clear, someone who works in the cancer clinic knows that we need more collaborative practice, the question is, is interprofessional education the best way to get us more collaborative practice. In the absence of accreditation standards that require me as assistant dean to implement interprofessional learning, this is just one of a list of things that might help. Lots of people want to do curriculum reform. So what's the piece that tells me that making this change to interprofessional education right now, is what will make the difference, because making this change may or may not get us to that point. If it's not interprofessional education, leave me be, let me find what will make the difference and go with that.
- We can't move this at the services level without academic grounding. If people came in to the system assuming this is just the way you do the work, because you've trained and educated with them, then it just becomes the norm. However, we need to figure out if the team learning should happen before they hit the floors, or when they hit the floors. Because before they hit the floors, it's not a reality-based exercise. Yet after they hit the floors, when is the time to do team-learning?
- In the absence of evidence that this leads to what we want, and in the absence of accreditation standards that say we have to do this, is this the right way to go? It's very difficult for interprofessional education to become the signal versus the noise.
- As an academic I'm all for us increasing the research agenda, but realistically, that's a long-term project and a lot of money.
- This is not the only form of evidence. Decision makers don't just look at research evidence. They look at everything, and we need to remember that. There is the experience of practitioners who've lived an experience. There is evidence available, and we need to start thinking about evidence as a bit less stuck in the rigors of research, and really think about what evidence is. Perhaps evidence is five people saying "this was great, I loved it". For the research community, that's not really evidence, but for decision-makers it may be.
- We also need to provide evidence at key decision points. You have windows of opportunity to move things forward, and those usually occur when things go wrong. We need to make lemonade out of lemons right now. Now is the time to start proposing something new. Right now we have a healthcare system that is realizing that no matter how much money you throw at the system, you'll still have problems. Our economy is worsening, so there's not the same money available. All of us are thankful when a health system problem comes up and we were NOT working that case, because

therefore but for the grace of god – we’ve all been there and chances are, we all would have made very similar decisions when faced with the same resources, the pressures and the infrastructure we have. We recognize that fundamental changes need to occur, and decision-makers know that and are looking for opportunities.

- Focusing on the health human resource crisis/shortage as the reason why we’re looking at interprofessional education instead of looking at it as ‘if you don’t have that collaboration and communication things will go wrong’, I didn’t see how the HHR crisis really fit here it seemed misplaced. I was surprised to see it in there. The CQI/TCM reference is unnecessary and not sure why it’s in there either.
- Is interprofessional education about changing skills and competencies? I don’t see anything about that in here. Being trained together and learning shared competencies, there’s some very clear lines drawn in legislation, but there’s not much here on the employer’s side. I’m on the employer’s side and haven’t worked on the academic side, and I can tell you we’re also very siloed in many places. We have an allied health group which is revolutionary that they work together regularly, but in other areas we’re very siloed. We’re set up a lot to not move forward.
- It’s been my experience that interprofessional collaboration takes more time and I think that’s one of the elephants in the room. People will say “I don’t have time for that, I don’t have time to talk to all those people about this patient”. Because it does take more time, I think we need to address that issue. We can’t pretend it isn’t there, and if so, then we have to look at that Human Resource question. When is it appropriate to provide this model? We have to address the whole issue. You might need more people because it takes more time. For a lot of staff who haven’t received interprofessional education, it’s nice to be able to say “I don’t have time for that”. Address this up front.
- We don’t want to set up interprofessional education as if it’s a silver bullet. It’s not the answer to every problem in the healthcare system. You want to be really precise about where it can be successful and make useful contributions to healthcare. That kind of evidence would be very helpful in terms of people being able to plan how to use interprofessional education and collaborative practice.
- Coming from a practice perspective, how do you organize people? Because we do have leadership who bring the team together, whereas other parts are very siloed and to move from the silo to another structure, that’s difficult and something we’re struggling with. To have something that tells us what level of collaboration makes sense with what level of complexity, what kind of structure is appropriate to bring people together, etc. would be amazing. We need some evidence beyond what are the factors that lead to successful outcomes? And they aren’t the same in every situation. It would be great to tease that out to a different level.
- Interprofessional education and collaborative practice should be driven by the needs of the people, not by anything else, and that is not a strong point that’s made here. The nature of the teams that emerge should be based on clients needs.
- The CHSRF did a systematic review of team-building and that was a lot of useful information, but not sure how much was evidence-based or how much cross-communication there is between the various groups. They talked a lot about the

structure and types of training. [Note, there's a lot of synergy and discussion between CIHC and CHSRF, so the linkages are there.]

- This is quite clear in many places, and worded really well. But it seems that the information here is all coming from the post-secondary side and informing the practice side. Has anyone done the opposite? There's likely a lot of work on the practice side, independent of the academic side, that would be useful to tap into.
- How do we hear about what's going on in the practice world? How do we find out about it? How do we learn about it? There's more than one type of evidence, and there should be many sources of evidence. It's easiest to pick up a book and read a study than actually try and find out what's happening in the practice world. Especially when the practice world might feel that they are alienated from a document like this which is clearly academic. How would my voice fit on this sheet? Well it wouldn't, but I bet I have experiences in my practice life that would be far more applicable and valuable to people than reading about the definition of TCM/CQI.
- I thought I knew the difference between interprofessional and interdisciplinary until I read this. Point two of the FAQ is terribly confusing for that reason. I really don't know why this has to be addressed, because we've used interprofessional for quite some time. There might be some academic somewhere who cares about the difference between the two words, but I think for the rest of us it's old news. I wouldn't waste paper on it, especially since you're just confusing people.
- We're busy enough trying to solve the intraprofessional issues in medicine, between various sub-groups, that moving on to interprofessional is probably beyond us right now. I've been sitting here thinking "gee, now I have to work on interprofessional along with multidisciplinary and intraprofessional".
- There's a sentence that reads "evidence indicates that a lack of communication and collaboration between healthcare providers can seriously harm patients", that may be true but I think the more compelling evidence is "does better communication improve patient outcomes?" It needs to be a positive statement that's being explored.
- There is inconsistency. It says interprofessional education can enhance practice, improve the delivery of service, and can also have a positive impact on patient care. But in a different section it says, "however, in order for decision-makers to reallocate funding and resources, more information on the benefits to patients and the healthcare system is needed. Evidence makes the best case for interprofessional." I agree with the latter statement, but it seems to be inconsistent with the previous one. I don't think the evidence is there to the extent that we would want it to be.
- The document is trying to say interprofessional education is important and it has some benefits, but it's also saying 'there's not much out there but it is important', so it's trying to balance those two messages and it's kind of confusing. It might be helpful to articulate it that way. "Some advances have been made but we need additional knowledge."
- This would benefit from examples, for example, mental health – someone who has a chronic mental health illness and is frequently hospitalized – is in that cycle. So many cycles are out there that don't talk to one another (medical to nursing to social work). If we had examples in terms of how when professionals work together to meet the needs

of a client it makes a difference to that individual's quality of life, that would help. You could put a lot of examples in here very effectively.

- Maybe we also need to look at those places that become interprofessional out of necessity. Are there examples where it's happening that we can be learning from? What about in remote areas where there aren't a lot of health providers, or a lot of one kind of health provider?
- I think the HHR planning thing is a poison pill and will offend people. You may have to counter that, because people will get upset about it. People think collaborative practice is an attempt to replace them with someone else. So you may want to consider turning it around and saying interprofessional education and collaborative practice is not about replacing one profession with another, but it's about helping existing professionals work better together.
- What's the primary purpose of interprofessional education? Ensuring the client receives the best care should be the best focus, which may mean others don't do what they did in the past. It may mean that. But it should come down to two professionals working together and respecting one another. If you have people working together in an IPE team where the patient is the focus, it's no longer theoretical. That can work effectively. But if you're in a different environment and you don't have the patient there, the focus is really on protecting your profession rather than the patient.
- I worked for 10 years here in the HIV clinic which is another example of interprofessional collaboration. If you speak to the people who have actually practiced in that way, they don't feel protective of their profession. It's when you're trying to initiate it and get the momentum going that all of these reasons why we shouldn't do it come up – the fears, the defenses, the turf protection.
- I was surprised to see the reference to HHR. Do the majority of people think that's why interprofessional education exists? Hearing it is a real surprise because in everything I know, it's been the other way around – enhancing quality of care to the client. That's been the focus.
- Similarly the reference to wait lists is in there, is it only one professional who has to see people? Some of this is because of the political agenda. Do you have to go after those or are you afraid of those questions? It's not driven by HHR crisis and shortage, there are a lot of things that drive this.
- The larger document does not refer to the shortages/HHR thing. It's as if it's been plunked into the summary without any kind of basis in the reviews that have been conducted. However, different audiences are looking at different information. Maybe one document can't be created that summarizes it for everyone. This might be three or four different audiences, all interpreting this in different ways.
- Has anyone looked at the non-health professions? Construction for instance - if you don't have a bunch of people constructing your house, it won't get built or it will fall apart. Can we look to any other industry? Or are we so complex that you can't compare it? For instance, the airline industry, which we try to compare it to, but is it too complex?

- Often the employer is missing from the discussion – regulatory, students, accreditors, educators look at this stuff, but employers don't always have a voice.
- If I go in with a sore throat, I don't need a dietician. So we need to refine this so that the right group or groups are getting interprofessional care. It isn't necessary for everyone at every point of access to the system.
- Sometimes when you read the studies and work that academics have done, you wonder if they have any clue what happens after graduation and that the world out there might not be what you think it is since you haven't practiced in a million years. It would be useful to remember that we don't have to write everything for an academic audience. If there's no proof of something, except 20 people agree that something worked, that's evidence enough for me.
- We need to really remember that there are lots of different types of research.
- Maybe add a question about turf issues and so on. Deal with the problems head on. Is this about replacing health professionals with someone else?
- How can students learn interprofessional skills? The narrative doesn't address the question. Most studies report students enjoy interprofessional experiences, doesn't say much. What are the experiences they enjoy? What are the ways they can learn? People's reactions aren't sufficient evidence, and it doesn't address the question of how people learn.
- Table #3 goes into the studies, but there's no real discussion about the quality of studies, which is mentioned elsewhere. "5 of the 6 reviews report positive learner outcomes" and lists the five studies. Where's the sixth? The only one not listed is the one that's earlier characterized as rigorous. So it's not a robust finding but it's presented as though it is, which has the potential to really undermine the credibility of the report. It's important that researchers have to fully account for what they read. There's a spin put on it that doesn't reflect a true state of knowledge.
- When you look at the title, the focus is to get people involved and interested in doing research. So you want people to get interested, but you can't ignore the evidence either. You need to somehow balance both the fact that the information isn't there, plus the fact that you want the information to be there.
- Add a section 'limitations of the evidence to date', especially for people who are reading this for a non-academic purpose. The context should be clearer.
- As an employer I would like good examples of practice, useful practical ways that interprofessional education has worked and real-life case studies. Give me simple, give me sweet. Give me something useful. Give me what has worked without the bells and whistles. "This is our interprofessional program, this is how we ran it, this is what happened". Best practices and examples would be really helpful.
- The documents don't refer to primary healthcare at all, which seems a bit strange because at least here, the one model we've tried to promote interprofessional collaboration in was built on the primary healthcare fund. So it's strange to not have that. I think it would be important to reflect interprofessional education back through that primary healthcare lens, especially since there are primary healthcare concepts in that.

- One of the key challenges is that we don't have the funding. The primary healthcare fund assumed the resources were there if we organized properly, but in reality, we needed resources that weren't committed, and when the primary healthcare funds ended, we realized it wasn't about organization. We actually did need the money. That recognition needs to be out there. Educating people takes a lot of time and energy and you need to have the money to go with that.
- Community is mentioned in there once, but there also should be discussion about working with community collaboratively. We really haven't touched on that. It's not just about the inside systems, but the outside systems as well. One size doesn't fit all, and you have to work with communities to make sure that interprofessional education and collaborative practice are appropriately administered.
- The federal government's approach to interprofessional education is a provider-focus approach, which is fine, but if you're talking about social policy and chronic disease, you need to talk about community and population health and the patient themselves. That's a good opportunity to look at the broader impact of interprofessional education and collaborative practice.

St. John's List of Ranked Priorities

1. Removing the focus of HR shortage
2. Where is the patient in all of this? Switch focus to quality of care
3. Who are the correct audiences
4. IPE vs. IPC – how do they relate?
5. Students reactions to IPE experiences is not evidence that it works
6. Turf issues
7. CQI and TQM – question #9 is out of place
8. Evaluation of IP practice
9. Define the best application for IPC
10. Other types of evidence
11. Providing examples & success stories
12. FAQs into categories – researcher vs. practitioner

VANCOUVER, BRITISH COLUMBIA

- This is a helpful document, but what I would really like to see is evidence related to the outcomes for patient safety and from the perspective of a regulatory body. Our concern and mandate is to protect the public and our concern is patient safety, so broadly speaking we're concerned about the provision of competent, safe, ethical care by Nurses and Nurse practitioners.

- If I look at interprofessional education as the target, the extent that it's linked to other kinds of variables and outcomes that you could argue are related to interprofessional education, such as outcomes related to effective teamwork and putting the client at the centre of care and involving the client with managed care/client ownership of care. We have all of the work of the CPSI and the PHAC and I'm wondering what the linkages might be between CIHC and those organizations and to link those and use similar or consistent terminology. That's a question I'm looking at in terms of competencies.
- The linkages come more on the practice side, the education piece leads to collaborative practice. And collaborative practice positively affects patient safety and teamwork and public health, and that evidence is emerging more strongly.
- It seemed in the document that it was linked primarily to HHR and doing more with what we have and quality care. But the real clincher for the regulatory folks is safety.
- How do you interpret the dots between interprofessional education and regulation with members who are regulated? We interpret collaboration in relation to teamwork and the healthcare team and the development of the healthcare plan that involves and works with the client. It's really tricky to word things that show or gets across the message that the client is the centre of care in collaboration and the client is fully involved. It's not a team of health professionals without the client. The professionals don't determine the care that's provided to clients, without the client being involved. The regulatory bodies are quite sensitized to that.
- Depending on the level of the client's ability to be engaged, or the ability of the family to be engaged, it's really imperative to ensure the professions are working well together to provide the proper care in briefing the family and the patient. I'm concerned that we don't lose sight of the fact that health professional teams are working together effectively for the good of family and patients and THEN include the patient and client.
- When I'm looking at the definitions, I think there is a problem with communication, collaboration and hierarchy. One of the terms in palliative care is client-centred and family focused care. But often we miss the tension between, for instance, a nurse who is competent as a nurse and the desires and goals of a patient, and how do you resolve that. Being patient-centred may not mean we can always provide exactly what the patient wants balanced against the knowledge of the health professional.
- I read somewhere where it was said this was developed because there wasn't anything else like this that was easily understood, so I'm wondering what audience this would be for? It seems fairly high level [accurate].
- What strikes me about it, reading it now, is that from the policymakers perspective is the process of what gets people to the collaborative practice, this speaks much more to the interprofessional education than the collaborative practice piece. If it's aimed at policymakers I wonder if in the next version or final iteration, if an equal part about collaborative practice needs to be in there. If we say we need collaborative practice and this is how it works, then this version, the interprofessional education is just how we get there.
- I thought the look of it was fine. I thought it could have more oomph and that's related to the teamwork and patient safety and outcomes more, it would have more oomph.

Not just relating to the HHR planning and quality of care, but specifically about seriously harming patients if we don't do this. Bring this out to the foreground if possible.

- Having being away from discussion on interprofessional education for quite some time I was pleased to see how simplistic the description provided was. It's actually an easy, simple concept broken down and easy to read. I thought it was a simple, easy read, and easy to understand, but I agree it needs a bit more oomph.
- In general it was straightforward and easy to understand. There was a gap or two. One potential gap is you have the difference between interprofessional and interdisciplinary, but we're missing inter-sectorial, (especially with the social determinants of health), how is this different again from interdisciplinary and interprofessional. The PHAC talks about this more. In some of the examples you've alluded to this – ie, housing system, air traffic control, etc.
- In nursing we would use intersectorial if planning something related to patient care – discharge planning or some sort of other reference to continuity of care/care management. The concept is certainly there for most of this.
- I have a comment about the example under #2. The example implies that the team works out what's wrong and then presents the plan to the patient. That's how I read that, instead of working with the patient to develop the plan, which would seem much more respectful.
- The other thing about language is that the evidence-based terminology has changed to evidence-informed, and that's what the CRNBC uses now because it's changed in other circles. We might want to look at that.
- Is it the interprofessional education that's the strategy or is it the collaborative practice that's the strategy? It's almost like this is one small part, but the real study has to be on the practice side, because this is trying to say that interprofessional education is useful, but without knowing why – that collaborative practice is the result – then what's the point. You can't educate people to do interprofessional so they can go off and work by themselves. That would be pointless.
- Collaborative practice is the part A for this audience, with everything else feeding in to it. For policy and decision makers, the collaborative practice piece should be front and centre, then are you alienating them by providing the interprofessional education piece without the collaborative practice piece when they aren't all that interested in it. It's better to say that collaborative practice is what we need. "Great how do we get there?" and then you give them the interprofessional stuff, but not before.
- If this came across the desk of someone at a regulatory body, if it raised the matter of safety or competence for safe practice, it would catch their attention, but as is, would not seem relevant.
- If someone would perk up around patient safety, would it be acceptable to change the title to that, whereas a CEO might prefer call to action around being prepared for the future of health care provision. Is it acceptable to change the title of a piece depending on what the person is most interested in?
- Really this is an executive summary of the report, and in that case, we need to acknowledge that and therefore this wouldn't be the document you'd want to give out

to CEOs and others in the healthcare system. You would need an actual marketing piece to get away from the research-speech.

- Right now this speaks to the vacuum.
- If this came across my desk, I would think “ok, here’s some research that might be of interest when I get time, at night…” as opposed to something I might want to read right now.
- What are interprofessional education skills? These are referenced in the document. How can students/practitioners learn interprofessional education skills? What are these? I assume these are skills for practicing interprofessionally, skills that you would apply to your practice. Interprofessional skills sounds more like a skill for teaching/learning. The concept of skills is somewhat contentious. There’s a difference in learning about interprofessional that doesn’t mean you’ll BE an interprofessional person. Learning about the skills around interprofessional education doesn’t necessarily mean you’ll have the ability to actually do it.
- I think related to that, the ingredients for successful interprofessional education – having interprofessional education embedded in the system, I wrote down here that it’s practice in a face-to-face setting. It needs to get to that, beyond knowledge to performance and into the practice arena.
- The literature talks about changing cultures which implies more than developing a skill-set for effective communication. It’s about changing perspectives, attitudes, beliefs and assumptions. In order to change from silos to a culture of collaboration, that transcends skills.
- The ingredients for success are a bit thin. If I read this and didn’t know what interprofessional education was I’d think you were stating the obvious or being too simple. They’re all pretty obvious without any meat to them that helps me understand what the key ingredients really are. How would I engage the community? I’d rather see this reframed, maybe not so many of the principles but something substantive. So for instance interprofessional education should be embedded. Link that to principle that in order for practitioners to practice collaboratively, interprofessional education needs to be integrated into the education of entry-level and experienced practitioners. There has to be more to it than just “embed it”. Indicate where you might see it on the continuum of learning. If someone is going to use this to inform their world, they need to understand what these mean within their world. They need something to work with that will help them report to their board something specific. Find out what we’re doing that helps me understand if I should embrace interprofessional education in this organization and here’s some of the things you might want to look for.
- Interprofessional education should be embedded in the system. What system? Education ? Healthcare?
- It would be ideal to see what needs to be done in education separate from what needs to be done in healthcare, so looking at it as a policymaker, I could see what had to be done within each arena. It’s not that cut and dried, because you need both to combine, but a better sort – who’s leading what and how. It would be more helpful if there were some different headings about where the lead should be coming from.

- I would like to see more tangibles like “champion within organization” who will embrace this. This is far too motherhood. We need more specifics rather than staying this high level.
- What’s the need for the box with CQI and TCM, when you’ve only used it once in the document? That box takes up a lot of space for what? You could use the real estate better for something else I think. But you should probably highlight somewhere what CIHC is.
- Emphasize the call to action and incorporate more substance into it so it’s more likely to be read. Get involved in..... ???? What?
- This is caught between two worlds. It’s great to do, but I think it will irritate policy and decision-makers to have to read this thing which is about interprofessional education , but has no linkages to collaborative practice. It doesn’t really work. I think you can’t do this version without the collaborative practice version. That has to come first, especially for this group of stakeholders.
- Evidence makes the best case – and yet we’re saying there isn’t much evidence. It isn’t exactly true to say you can’t compare qualitative and quantitative. You’re telling me I need to do this and that evidence makes the case, but you aren’t giving me the information I need.
- It’s hard to see the transition between interprofessional education and better health outcomes. Without the link through collaborative practice, it doesn’t make sense. You need to really turn this on its head and look at collaborative practice, not interprofessional education, as being the link between the two. You maybe can’t do collaborative practice without interprofessional education, but without collaborative practice, there’s really no point in doing interprofessional education. Interprofessional education for the sake of itself is kind of silly.
- In the vast range of things I need to do, why do I need to pay attention to this? If you have the evidence to say that interprofessional education is the thing that matters, then as a policymaker I’m going to listen to what you have to say and I’m going to think yes, I do need to pay attention. But if you can’t tell me why I need to pay attention, I don’t have time to sit around and try and figure out how to fit this in my world. There are a lot of things that will help the health system. Prove to me that this has more value than any other.
- What we’ve learned about the quality of evidence and what we need to strengthen the evidence are linked to funding proposals. This section could be strengthened by talking about outcomes, how interprofessional education is viewed, experiences, perceptions. Build in the evidence now, whether it’s qualitative or quantitative or anecdotal. So long as it’s linked to something (ie, patient safety), that’s what really matters.
- The potential interprofessional education offers is probably greater than the need for evidence. So spark the imagination. Reorder how interprofessional education is used to focus on that part of a policymaker that makes them want to get involved.
- This is very impersonal. There’s nothing in it that tells a story or makes me gravitate to it. There’s nothing compelling or personal in it that makes me think “ok, this is

meaningful and I understand why it matters.” This doesn’t speak to the audience. It just speaks.

- The consequences of not doing this are tragic – people DIE because we don’t communicate well and we don’t work together well. Patient safety is fine, but picture what that looks like. It means you don’t want someone to die because they’ve not got a sense of wanting to work with other people. Nothing in this brings it to life.
- If I’m a CEO and read this, it needs to speak to me first. But I also have to sell this to my board of directors and other people, so somehow I need to feel like this will make me want to champion this. I don’t want to think “ok, I get this, but how the hell do I use this to inform or convince anyone else?”

Vancouver’s List of Ranked Priorities

1. Remember and note that the patient is the centre of collaborative care
2. Reorder the "how IPE is viewed"
3. bring out patient safety
4. content of a 1-pager must be geared to audience
5. how can students/professionals learn interprofessional collaboration? (not interprofessional skills)
6. “Evidence makes the best” and then “there’s not much evidence”
7. emphasize ‘call to action’ (title should match content)
8. concrete steps for action ‘how do I do something about this?’ (ie, what is it, why should I care, steps for action) - key success factors/call to action
9. “What have we learned about the quality of evidence”
10. Get rid of the ‘difficult to compare qualitative and quantitative’ – not true, they can be merged
11. Make a story of why IPE is so important eg, people are dying vs. patient safety
12. Delete definitions box

WINNIPEG, MANITOBA

- For retention and patient safety, interprofessional education and collaborative practice is an absolutely key and important initiative for us to pay attention to, so this is a very valuable opportunity to comment on a document that I think is widely useful and could be really helpful. I definitely think it’s useful getting information like this, because often we don’t either have a chance to get it in our hands, or worse, we get something that doesn’t work and we don’t have an opportunity to feed back on it.
- Who is the intended audience for these documents? Is it the policy decision-makers within the health industry? Deans within health as well? [yes to all – wherever someone is making policy decisions about whether to implement interprofessional education].

Regulatory is it important enough to make regulatory changes? Academic is it important enough to make curriculum changes? For COPSE is it important enough to fund? In practice is it important enough to start implementing change?

- As someone who works in the health authority, if this came across my desk and said interprofessional education, as it does, I would lay it aside because the E [education] is not my business. The E is helpful if I'm going to have the C [collaboration] part follow, then it would be great if people were prepared to do that, but my bigger worry is getting practitioners who are already out in the field to begin to do this. What would be more helpful to me, but this may not be true of all policymakers, but that would be a fact sheet about why it's important that care be collaborative, that interprofessional practice occurs. And from that falls then we have to educate them that way and teach them that way. For me this is too focused on education. I would say that the education piece should flow from the collaborative. Research shows that collaboration works, so how do I educate people for that setting? The title alone would make me lay it aside, the title would lead me to think this is plea to allow groups of students to come together in practice settings, and if that was the intent I would think about that, but otherwise, I wouldn't respond.
- Maybe it's a bit of a misnomer, but I'm seeing this 2-ager on interprofessional education seems to really cross the border into interprofessional practice as well, but it only says interprofessional education on the sheet. So maybe it's a matter of calling it something different – just interprofessional. Really there are only two components – education and practice, so that would cover it off.
- My impression from the second column at the top is that the quality of the evidence is limited and variable. So it's a bit of a weird leading statement. There some evidence, but the language makes it seem like a really weak argument. It's almost suggesting that we really think intuitively that interprofessional education is a good thing but unfortunately there a dearth of information to back that up. And intuitively I don't think anyone would argue against it, anecdotally we hear it's good, but is there evidence in terms of outcomes, costs, systems savings, human resource crisis management? How does interprofessional education really have some impact on mitigating that?
- The only major problematic paragraph was under why does interprofessional education matter, there's no tangible link between the evidence outlined in the document and the HHR Shortage. It speaks to achieving efficiencies and increasing patient-centred practice, but the relationship between interprofessional education and the crisis is really weak. There doesn't seem to be very much evidence there.
- Are there institutions that could be lifted up as champions of interprofessional education or collaborative practice that could be pointed to in this document, that could be highlighted as successful examples ? That would strengthen this document. Tell about what has been done, what has happened, how it has been made to work. Provide examples.
- What evidence are you looking for? From a Manitoba health perspective, if I were to take a proposal and submit it up to the deputy, minister or treasury board, it would have to be more than the qualitative measures. You can't argue against how great those things are. But in terms of support at a political level, the question would be "alright

what does this do for that patient out in Winnipeg or Selkirk or whatever what is it going to do for them and we here is the evidence to support that the outcomes for these people will be improved through an IP model”

- I just had a large proposal go to the caucus of parliament yesterday on this very issue yesterday that has an interprofessional and practice and education component. It’s about linking oral health to comprehensive health and the study plan is to track patient health outcomes from preventable care services in high risk populations over a four year period. Look at the medical expenditures for those patients over time in groups that get the services versus groups that don’t, while also tracking quality of life and outcomes as well. But providing actual numbers on the medical costs that are saved over that period, subtracting the care costs of course, but having that inform policy decisions in terms of how we might save money.
- That’s a good addition or explanation for the section that talks about what we need to strengthen the evidence base. We need that kind of evidence to really move forward. But those are multi-year, very expensive, rigorously designed studies. That’s the only way you’re able to really show what you need to show. So we take the interprofessional component but you also have the patients receiving the services tracked at the same time. So there’s two components – measuring how the team reacts to being interprofessional and measuring how the patient responds to it.
- To me two parts of this page would get my attention. Interprofessional education has the potential to enhance practice, improve the delivery of services and make a positive impact on care. (But I would say interprofessional collaboration or practice instead). And the one that says “it can and has been shown to be delivered effectively in a variety of clinical settings.” Those I would put at the top of the document and then show why it’s true. That’s the important stuff you’re looking for with the policymakers. The definition isn’t that important.
- People read the first two bullets and the last two bullets. Then show me how it’s better, and don’t talk about education, talk about care, that’s what you’re trying to sell.
- I had difficulty with the two definitions. I haven’t been involved with any of this so far, but I couldn’t see what the difference was between the two. At one of our meetings recently I was amazed at how the physicians saw interdisciplinary (within medicine –they have multiple disciplines within medicine). That was why we used interprofessional but now we’re missing a whole bunch of people because we think of professional as regulated.
- Sometimes I think it’s better to describe interprofessional as a comprehensive interprofessional care plan (CIPCP??). That takes us to people thinking that the background knowledge that informs those decisions is interprofessional education, but how people come together and bring that knowledge to bear is what it’s all about. So people need to think more about that concept when they hear interprofessional
- Do we even need to mention interdisciplinary? As soon as you introduce another term to compare it to, then you lose what you wanted to talk about. Just stick with what you believe interprofessional to be. I wasn’t quite sure what the differences were because I looked at the example of a patient having trouble swallowing, and people needing to work together to figure what’s wrong, but that’s also the definition of interdisciplinary.

So maybe we should just stick with interprofessional and define what we think that is. The advantage is that interprofessional is newer in people's practice, so they might think this is new and something they should listen to.

- So maybe the definition we need is something like “interprofessional is a term that implies collaboration around patient care and goes beyond the multidisciplinary language and practices of the past.”
- Communication cooperation and collaboration is stronger than inter, multi, intra and so on. But we can't lose sight of the fact that we need to educate people, but maybe the education doesn't have to be all inter. It would be good to get students together to practice skills collaboratively before they get in the practice setting, but they can learn independently how to do interprofessional collaboration.
- Whether we have the right title simply determines how others recognize what we're talking about. But if we focus on things other than patient outcomes, we're chasing the wrong rainbow. In practice, correct me if I'm wrong, but it seems to me in practice if indeed health care teams, because of funding available are able to jointly stand at the bedside and create a plan of care there and then, that would be superb. A Cadillac of patient service. But I suspect most often, one or more professions is missing. So the next key piece is that the students and practitioners know when to refer. And that is as much part of the education as anything else. That's part of understanding the other professions role and the knowledge that comes along with that.
- What happened to IECPCP? The P is there for patient care. Where did that term go or was it just unpronounceable? Now we're hearing interprofessional education and practice. But we can't lose the other P, because then we're losing the patient. So even though it's a horrible acronym, the whole thing needs to be together. The goal is student outcomes and patient outcomes. And you need the whole acronym for that. Students in the interprofessional education years can't improve patient outcomes. That's why the policy people are now saying “whatever happened?” because the problem was that Health Canada gave funding for education, but we didn't measure anything on the other end, so none of us can tell you how the patient benefitted, we were measuring the students!
- The danger is that a lot of people are disconnecting with IECPCP because they don't see it going beyond the E to the P so we have to make sure that that's the next step – the practice step.
- There's a certain backlash to professions thinking they own the world. In tough economic times that backlash gets bigger unless you can show you're making a difference for the recipient of care.
- I would like to see measured:
 - Whether people know who else is out there that they should consult and whether they consult appropriately the right people and get the right folks around the patient
 - Whether interprofessional education/collaborative practice makes any difference on retention of staff (not sure how you'd measure that – researchers would have to figure that part out)

- Whether interprofessional education/collaborative practice helps recruit to areas that have high vacancy rates. If I think of an intensive care setting, where no one's ever tried sending a group of students together, that I know of, they are very interprofessional in some ways, very collegial, they work together, they tend to have docs 24/7, so you don't have that in and out of doctors, and they might label themselves interprofessional, but I'm not sure if that's what makes care better there
- This is a continuum, starting with education, flowing into practice and that practice having an impact on the patient and the outcomes. So for me, there's an end point measure to this and that is patient outcomes, going back to the patient at the centre, because we sometimes have a tendency to take that for granted (not ignore it). For me, all of those other things, but at the end, how does this at the end of the day effect care, and does it affect care? Or do we just have a bunch of people who are learning how to work and play well together, and they work and play well together when they're in practice, but it makes no real difference. It should, but we need to be able to measure that.
- I would expect care would be delivered more efficiently, in that, if you have the right people involved at the beginning there's less referral time and so on. It would be interesting to see if that could be measured somehow. Perhaps measure the timing factor?
- Is there an impact on length of stay?
- Do we need evidence? I wouldn't ask a government or health care system to change their policy if I didn't have hard data and didn't have some way of proving cost and effectiveness.
- For the deans at the table, my understanding is that the concept of interprofessional education or interprofessional practice/collaborative practice is intuitively fully acceptable and promises all sorts of benefits, and the only way for us to figure out if it really does is to get started. Because we're at the front end of the education side, that means we have to make sure that the regulatory bodies that we answer to understand what we're doing and are also on board, then we need to sit with the practice sides and see how this actually works in practice, and how students react, if the curriculum is affected with collaborative practice and after that, once we have that laid out, then the system needs to provide some evidence. Because without it we can't define why we're spending the money in the first place, never mind that patient care has to be improved as well.
- We need two sets of evidence, one for education – the students and the programs and the outcomes there and then a separate set of research, does it make a difference to patients.
- The education piece is not that large, the amount of overlap in the professional programs is not huge at the education level. But the practice would be significant in time once it gets going. So it very quickly connects to the practice that you're talking about. Yes the education has to be there so the students come with the right knowledge, but by itself it's not a large part of the total part of interprofessional collaboration.
- It's not mutually exclusive either. We can set up clinical trials for students and collect patient outcomes at the same time. This is happening somewhat with the WISH clinic,

but what kind of outcomes and data are being collected, are there controls, and is it the kind of information that's useful? The potential is there, are we using it. It would be helpful to have researchers ask the same question the facilitator just asked "what research would help you?" I could fill their ears with suggestions.

- You can educate and train people, but if they don't have enablers and facilitators of their practice in place they won't be successful. We need to look at administrative and infrastructure components as well.
- Do we need evidence to go forward with the educational component or interprofessional education generally? We are already moving ahead at the university to move the education piece, but there's no point in going ahead with interprofessional education without collaborative practice.
- In fact it's dangerous to get too far in the education piece, because if we go too far, and don't catch up with the collaborative practice piece, the graduates are going to get frustrated, and won't want to work in those settings. If they've become used to working with others as peers and colleagues and calling on them for help, and now I go into the practice setting, but they have a siloed approach and don't work together. We could make matters work if we go too far on education side and don't keep up with practice side.
- How much do we want to see an improvement in patient outcomes, or are we happy with the fact that people/providers are happier working in this environment? Job satisfaction and patient satisfaction are important too. So I guess the question, do we need evidence... what's wrong with the job satisfaction as a measure?
- I can't speak for government without seeing the costing of this but from government, we do lots of things for no apparent practical reasons, but we do them because they're good things. It's like space travel, we achieve benefits from doing it, so we go ahead, even if it seems like an impractical thing. We do it because it's there and intuitively we might think it's a good idea, and for me, it makes sense to me to do collaborative practice in this way. If we're going to go forward with anything like this in government, it might not be a high priority to do this, but we would be and would continue to be supportive of it, and maybe for no other reason than Ruby thinks it's great and we're on the ride with Ruby in the hope that there will be some positive outcome to this at the end of the day. There are lots of reasons to do it, but for us, the final determinant will be "how does this provide better care". We need the evidence. We need you to be collecting the evidence.
- There's a controlled phased in way to set this up. We have at least one pilot project that has been successful in terms of student satisfaction. There were two cycle projects that targeted pre-licensure learners, but it was hard to measure patient outcomes. There was high student satisfaction.
- What about finding out if there's a way to measure when practitioners learn from the students, and by having the students in a group? If the students have an interprofessional education background, do they bring that with them to the practice setting, and does it rub off on their mentors and preceptors? Because the argument could be that if you get involved in these interprofessional pilots, you may improve the collaboration among your staff. There's some qualitative data that's important though, because for instance

there were students who didn't want to go into a geriatric setting – not IT, not high tech, etc – but over the course of the study, they were requesting to go there, because word of mouth had told them that it was a good experience and a fun place to work and so on.

- So you're more able to work because your interprofessional/collaborative setting is attractive, then that's the kind of useful evidence we could really use. That's the kind of information that would help so much. Alberta has some similar data. Ontario might have some of that information as well
- My soapbox is that most of our pilot projects take place Monday to Friday 9 to 5, and it's much easier to be a team when you see each other and work together, my question is, how does it work to introduce interprofessional practice/interprofessional collaboration in a 24/7 medical unit for example? It would be neat to measure medical unit against medical unit, side by side, this one's more collaborative than this one, but why? What are the features causing that to happen? Is it timing? Is it composition? Is it time of day? What are the outcomes on those units? We have good databases on outcomes, so why not take two medicine units in terms of outcomes and attach to that what are the professions on that unit, and how do they work together and so on. Compare the outcomes.
- The document is really easy to read. At first I thought "oh god 22 pages" but I was impressed at how fast I could read through it. It's very well written, very easy to read.
- I don't know what CQI and TCM add to this page. We never use those terms any more so take those off.
- I'm not sure about the relevance of the air traffic controller reference. It just doesn't work for me. The patient safety stuff has really brought that into focus, and I assume that's the reference with air traffic. Include some examples, but just not air traffic controllers.
- I think it's quite useful but I have some issues with the content of some of the FAQs. The second one in terms of parallel construction. We mention the difference between interprofessional and interdisciplinary then we describe interdisciplinary first. If we're going to stay with that, switch around. But better, tank it totally.
- The answer to why does interprofessional education matter is very negative. Ok, what are some of the pluses, why only the negatives. Do we not have any answers? Then don't ask the question, because it's horrible.
- I don't think number four, how does interprofessional education research benefit decision-makers – I don't think it answers the question.
- When universities develop programs and submit them for program approval, they usually need to provide as much research as possible in support of the program application. So in the context of interprofessional education that would be an important thing to highlight.
- Maybe the problem is more in the question than the answer. How does interprofessional education benefit decision-makers? If you're talking about people in practice, the answer doesn't fit. If you're talking about decision makers accrediting education programs, it works better. Maybe how does interprofessional evidence

benefit patients? Or practitioners? The answer is trying to talk about wait times, is there evidence about IP benefitting wait times? Length of stays? Stuff like that?

- The benefit that's more clear is improving the workplace, and that one makes a lot of sense. Reducing wait times doesn't make sense. Chronic Disease Management fits as well. It's just wait times that doesn't make sense. But is any of this the result of interprofessional education or is it the result of interprofessional collaboration. We need to be clear that interprofessional education is actually fairly limited. It's JUST EDUCATION. We've done it. The education sector is somewhat in hand, we're moving that way, the schools are doing it, it's on the radar. So enough about interprofessional education, now let's talk about collaborative practice instead, because the practice setting is NOT doing it, and NOT moving that way.
- Now is the time to get involved????? I don't get that. Because now's the time to get involved but then it ends with researchers, so are you talking to researchers? What's the key message? It seems like it's aimed at researchers.
- What are interprofessional education skills? Is there such a thing? I'd take that out. Take out TCM and CQI for sure, and instead maybe say something like "there's a proven spillover effect on the staff if students come in an interprofessional group" If that's true anyway.
- Insert qualitative evidence. One way practitioners can learn interprofessional skills is to have students in their midst who have interprofessional background/skills.
- I'm still trying to find, with the exception of one reference, I see no indication of whether these studies were done in healthcare systems that were similar to ours (with the exception of the UK). Were any of these done in the US? I'm looking for something to support research findings or suggestions that may come of this. Their system is somewhat similar to ours. But I only see the UK referenced in here. So these studies came from where?
- Most of the reviews are searches of the worldwide literature, and the UK comes up a lot because they're way ahead of the game.
- Is there an organization where people can join that focuses on interprofessional education? [That would be CIHC, and our next phase will be to focus on practice and community and move in that direction – so the hope is that we'll get more people in there. We'd like to get away from academia and move into practice)
- CIHC should produce a similar format – 1 pager and then 2page FAQ, that's what we'd look for. Short is great, just make some changes in content. More evidence to support it. Some content modifications. It's good to work with. Make some edits. Include some quantitative data.

Winnipeg's List of Ranked Priorities

1. Separate IPE from IPC (or IPP) - give solid definition of each
2. What does IPC do to patient outcomes?

3. 'Evidence is limited' is less attractive vs showcase positive models & case studies demonstrating cross-sectoral collaboration (not only IP), "more evidence is needed" sounds more positive
4. insert positive, qualitative evidence
5. the end-focus is appropriate for research not decision-makers, what would be appropriate for decision makers?
6. eliminate TQM & CQI